ICD Coding Newsletter

First quarter 2004-05

Distribution List

- ❒ Health Information Manager/s HIMs)
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Department of Human Services

Victoria
The Place To Be

The ICD Coding Newsletter supports the clinical coding function performed in Victoria by providing relevant information to Health Information Managers, Clinical Coders, and their associates.

The newsletter, prepared by the Victorian ICD Coding Committee in conjunction with the Department of Human Services, seeks to:

- Ensure the standardisation of coding practice across the State
- Provide a forum for resolution of coding queries
- Address topical coding education issues, and
- Inform on national and state coding issues from the Victorian perspective.

The scope of the newsletter includes coding feature articles, selected coding queries and responses, and various information updates including feedback on the quality and uses of coded data (as reported to the Victorian Admitted Episodes Dataset).

If you have any mailing list changes or queries or comments regarding the ICD Coding Newsletter, contact the HDSS Help Desk:
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Coding features

Additional Victorian grouper modification for 2004-05: Z71.3 *Dietary counselling and surveillance*

As a result of a query to the Victorian ICD Coding Committee, the Department has examined the use of ICD-10-AM diagnosis code Z71.3 *Dietary counselling and surveillance*. This code currently has a clinical complexity level (CCL) of 2, for both medical and surgical DRGs.

Coders are reminded that all additional codes should meet criteria outlined in ACS 0002 *Additional Diagnoses*.

Even where it is coded appropriately, the Department feels that the CCL value is inappropriate for a code of this nature, and has written to the Commonwealth Department of Health and Ageing requesting that this be amended.

In the interim, the Department has created an AR-DRG 5.0 modification for separations in 2004-05, where Z71.3 will be allocated a CCL value of 0 before grouping to VIC-DRG Version 5.0.

Coders should be aware that your hospital generated DRG (that is, the DRG generated when you group an episode) may not be the same as the VIC-DRG (generated by PRS/2) unless your hospital has contacted your software supplier and asked that the grouper be modified to encompass this change.

Coding palliative care

Author: Carla Read, Health Data Standards and Systems Unit, Department of Human Services

This article provides coders with some clarification regarding the assignment of Z51.5 *Palliative care*.

Definition

0224 Palliative Care
Definition

Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. It includes care provided:

- In a palliative care unit; or
- In a designated palliative care program; or
- Under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation. (National Health Data Committee. (2003) *National Health Data Dictionary*, Version 12, AIHW)

The **services** provided by palliative care specialists include:

- Clinical consultancy/care
- Personal care
- Spiritual /emotional support/counselling
- Home care/support
- Education
- Case management/care coordination

(ICD-10-AM Australian Coding Standards Fourth Edition)

Background information

PRS/2 edit 498 *Palliative Care without Palliative Care Diagnosis* was introduced in July 2003 to reject episodes admitted under Care Type 8 *Palliative Care Program* without a diagnosis of Z51.5 *Palliative care*. But what about those patients who are not admitted under Care Type 8 but receive palliative care, or those patients who receive palliation during their admission? Is it necessary to code Z51.5 in these instances?

ACS 0224 *Palliative Care* should be assigned for all patients receiving palliative care, regardless of the clinical intent on admission. This means that palliative care should be coded when a patient is admitted:

- with the intention of palliative care only, or
- for acute (or other) care, and the clinical intent changes to palliative care during the episode.

The question that then remains is when is it 'appropriate' to assign Z51.5 *Palliative care*? To determine this, coders need to ensure that the documentation meets the definitions in ACS 0224 *Palliative Care* as shown above. It is also important to note that only one of the three dot points defining palliative care in the standard needs to be met to satisfy the criteria for code assignment (refer to VICC query #1938 Use of Z51.5 Palliative Care, published in the Victorian Coding Newsletter, May 2004).

The Palliative Care Sub-Program uses code Z51.5 as an indicator to monitor when there has been a component of palliation within an episode of another care type.

Examples

The following are examples of documentation that support the assignment of Z51.5.

Case 1
87-year-old patient with a diagnosis of large MCA territory infarction, with dense right hemiplegia, facial palsy and unconsciousness. Patient intubated on admission to emergency department. On day two of admission, after family counselling, the treating doctor documented that it was decided the patient was for palliative management only. Patient was extubated, kept comfortable, and died three days later.

Case 2
79-year-old patient with congestive cardiac failure, severe cardiomyopathy, chronic renal impairment, NIDDM. Initially given active treatment, but patient did not improve and on day four condition started to deteriorate further. As the patient was already on maximal medical treatment, the treating doctor made a decision that further medical treatment was of no benefit. The palliative care physician was called in to assess patient and a decision made to transfer the patient to the palliative care unit when a bed became available. Patient died 11 days after admission, before transfer to palliative care bed.

In both cases 1 and 2, the documentation meets the criteria in ACS 0224 *Palliative care*.

The following are examples where the documentation does not support the assignment of Z51.5.

Case 3
A patient is admitted with an exacerbation of COAD and in respiratory failure. The patient is treated in ICU and makes a slight recovery. In view of the patient's ongoing need for oxygen therapy and his co-morbidities of chronic renal failure and ischaemic heart disease, the palliative care physician is asked to provide an opinion. After consultation the palliative care physician determines that the patient is not ready for palliative care and the patient is discharged home to the care of his family.

In this case, although the palliative care physician provided a consultation, the intent of care was never determined to be 'palliative' and therefore code Z51.5 would not be assigned.

Case 4
A patient is admitted for management of pain due to bony metastases. During the admission the patient is seen by a representative from the palliative care team to determine the patient's eligibility for admission to the palliative care program. When the pain management has been established the patient is discharged home.

In this case as the intent of care for this episode has not been determined to be 'palliative' therefore Z51.5 is not assigned.

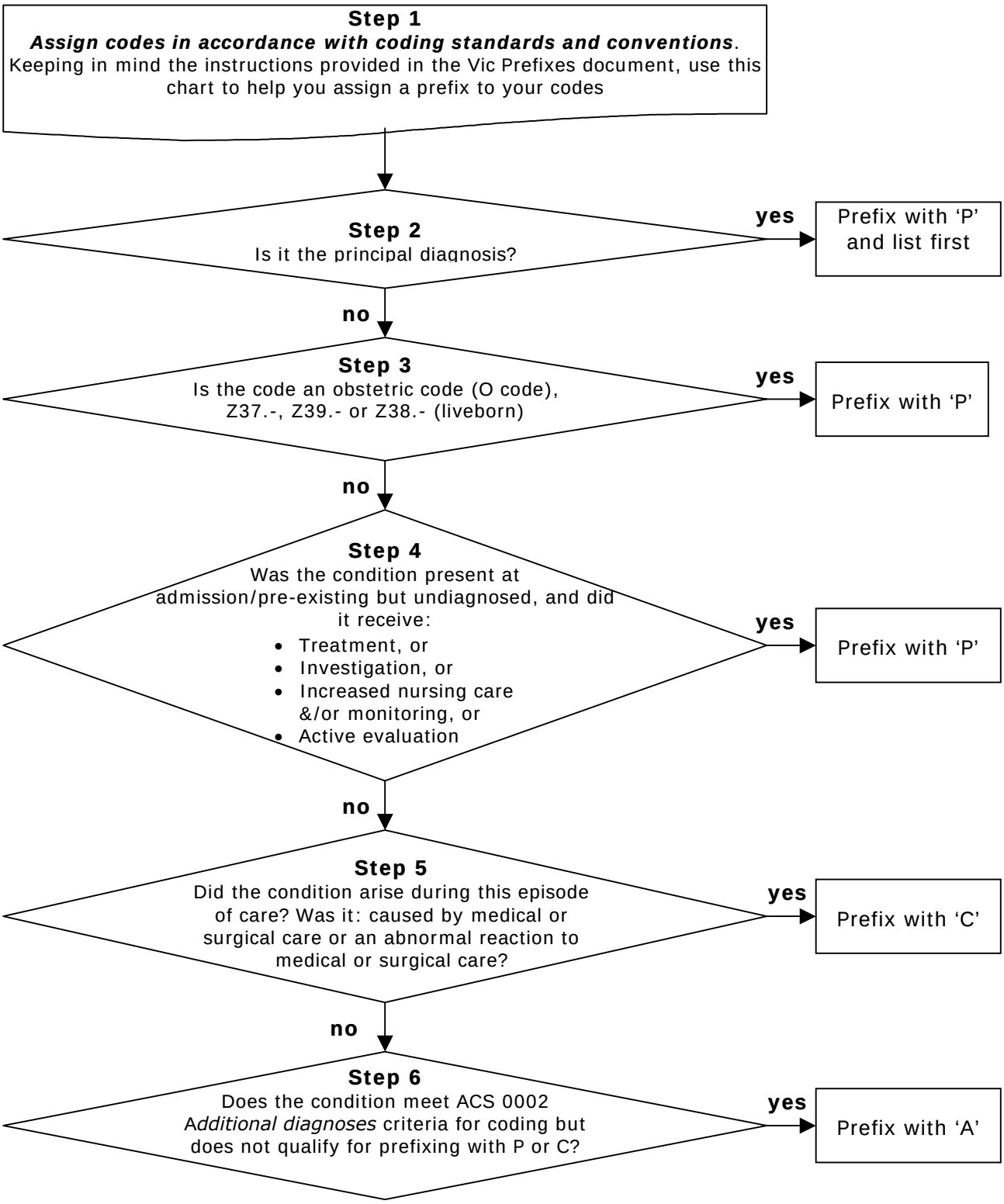
References

ICD-10-AM Volume 5 *Australian Coding Standards* Fourth Edition.
National Centre for Classification in Health ICD-10-AM query database Q1901.
VICC coding query #1938, Victorian Coding Newsletter May 2004.
Victorian Admitted Episodes Dataset Manual

- Section 4 *Palliative Care*
- Section 8 *Edit 498*

Assigning code prefixes

This chart, originally published in the 1993 Victorian Coding Standards, has been revised to reflect the updated Vic Prefixes document. Only those codes that are being transmitted to the Department of Human Services require a prefix.



Intraocular lens table

ICD-10-AM codes for insertion of intra-ocular lens specify whether the lens is *foldable* or *rigid*. The following list provides brand names and model numbers, and advises whether each lens is rigid or foldable. Note that some brands produce both types of lenses, thus it is important to check the model number as well as the brand name.

RIGID LENSES			
Brand	**Model number**	**Brand**	**Model number**
Alcon	CP10BG	Alcon	MZ30BD
Alcon	CVCIU	Alcon	MZ60BD
Alcon	CZ70BD	Alcon	MZ60PD
Alcon	LC80BD	Alcon	SK61CM
Alcon	LX10BD	Allergan*	AC51
Alcon	LX90BD	Bausch & Lomb	95BUV
Alcon	MC50BD	Bausch & Lomb	EZE65
Alcon	MC50BM	Chiron	SP38UB
Alcon	MC51BM	Chiron	6441B
Alcon	MC60BD	Chiron	6741B
Alcon	MC60CM	Chiron	C31UB
Alcon	MTA3U	Pharmica	722C
Alcon	MTA4U	Storz	P359UV
Alcon	MTA4UO	Storz	P525UV
Alcon	MTA5U	Storz	68UV
Alcon	MZ20BD	Storz	95BUV
Alcon	MZ60MD	Storz	121UV
Storz	121BUV	Storz	P359BUV

FOLDABLE LENSES			
Brand	**Model number**	**Brand**	**Model number**
Alcon	MA30AC	Alcon	SA60AT
Alcon	MA30BA	Allergan*	All models except AC51
Alcon	MA50BM	Bausch & Lomb	C11UB
Alcon	MA60AC	Chiron	C11UB
Alcon	MA60BM	Chiron	LI61U
Alcon	MA60MA	Staar	All models
Alcon	MZ30	Storz	H60M
Alcon	SA30AL		

ALL LENSES					
Brand	**Model number**		**Brand**	**Model number**	
Alcon	CP10BG	Rigid	Alcon	MZ60PD	Rigid
Alcon	CVCIU	Rigid	Alcon	SA30AL	Foldable
Alcon	CZ70BD	Rigid	Alcon	SA60AT	Foldable
Alcon	LC80BD	Rigid	Alcon	SK61CM	Rigid
Alcon	LX10BD	Rigid	Allergan*	AC51	Rigid
Alcon	LX90BD	Rigid	Allergan*	All models except AC51	Foldable
Alcon	MA30AC	Foldable	Bausch & Lomb	95BUV	Rigid
Alcon	MA30BA	Foldable	Bausch & Lomb	C11UB	Foldable
Alcon	MA50BM	Foldable	Bausch & Lomb	EZE65	Rigid
Alcon	MA60AC	Foldable	Chiron	6441B	Rigid
Alcon	MA60BM	Foldable	Chiron	6741B	Rigid
Alcon	MA60MA	Foldable	Chiron	C11UB	Foldable
Alcon	MC50BD	Rigid	Chiron	C31UB	Rigid
Alcon	MC50BM	Rigid	Chiron	LI61U	Foldable
Alcon	MC51BM	Rigid	Chiron	SP38UB	Rigid
Alcon	MC60BD	Rigid	Pharmica	722C	Rigid
Alcon	MC60CM	Rigid	Staar	All models	Foldable
Alcon	MTA3U	Rigid	Storz	121BUV	Rigid
Alcon	MTA4U	Rigid	Storz	121UV	Rigid
Alcon	MTA4UO	Rigid	Storz	68UV	Rigid
Alcon	MTA5U	Rigid	Storz	95BUV	Rigid
Alcon	MZ20BD	Rigid	Storz	H60M	Foldable
Alcon	MZ30	Foldable	Storz	P359BUV	Rigid
Alcon	MZ30BD	Rigid	Storz	P359UV	Rigid
Alcon	MZ60BD	Rigid	Storz	P525UV	Rigid
Alcon	MZ60MD	Rigid			

* Allergan is also now known as Advanced Medical Optics.

This list will be updated and republished as required. For any lenses not listed, please send the brand name/s, model number/s and identify whether the lens is foldable or rigid, to the HDSS Help Desk.

Data quality

Performance Indicators for Coding Quality (PICQ) data

Author Greg O'Connell, Health Data Standards and Systems Unit, Department of Human Services

PICQ 2002 indicators have been run against all 2003-04 coded separated VAED episodes submitted up to 17 July 2004. These were emailed to hospital contacts on 27 July 2004. Aggregated statewide PICQ results will be published on the HDSS website, using the 2003-04 final VAED consolidated file, in October with sites de-identified. Sites will be able to contact DHS to find out the identity of their site to enable comparisons between themselves and other sites.

As with previous runs, PICQ has engendered healthy discussion about some indicators. Prominent among them has been fatal indicator 101418 (Appendicitis, acute, without appendicectomy). There are circumstances where acute appendicitis will not be treated with an appendicectomy. These include:

- Where the performance of a more significant procedure, such as a hemicolectomy, is required instead
- Where the surgeon elects to treat the appendicitis conservatively until the inflammation has decreased
- Where the patient is admitted for a period of aftercare or convalescence following an appendicectomy.

For the next version of PICQ (PICQ 2004 - currently under development) NCCH will make this a warning.

Other issues include:

- 100190 *Division of abdominal adhesions code without corresponding diagnosis code*, is currently a fatal indicator, yet some numerator episodes are correctly coded. For PICQ 2004, NCCH will use a more inclusive list of codes indicating abdominal adhesions (for example N99.4 *Postprocedural pelvic peritoneal adhesions* will now be included).
- 101386 *Obstetric laceration of cervix without repair* is a fatal indicator. Related advice in *Coding Matters* Volume 6, Number 4 (March 2000), advised that perineal tears should only be coded when they are repaired. This did not apply to lacerations of the cervix, and therefore the indicator is being changed. Regardless, a patient with a laceration repair in a previous episode would have a code for the complication or pain rather than the laceration.
- 101528 *Chemotherapy session for neoplasm code as principal diagnosis without neoplasm code* is a fatal indicator, yet some numerator episodes are correctly coded. Use of Z51.1 *Chemotherapy session for neoplasm* is appropriate with diagnosis codes *outside* the C00-D48 *Neoplasms* range, where the code is listed on the library file as requiring a morphology code. For example D76.0 *Langerhans cell histiocytosis* is permitted with Z51.1 *Chemotherapy session for neoplasm*. For PICQ 2004, the NCCH will amend this indicator.

HDSS would like to encourage sites to continue raising PICQ issues for discussion. The quality of the feedback to date has been tremendous. Where appropriate, issues are passed on to NCCH for possible revision of the indicators.

PICQ 2004, which is for use with ICD-10-AM Fourth Edition codes is due out in October 2004, and will include approximately 90 new indicators, of which nearly half will be relative type indicators. Until this is released hospitals can continue to use the majority of PICQ 2002 indicators. For further information see:
http://www3.fhs.usyd.edu.au/ncchwww/site/7.3.1.htm#2002Ind

Reference:

National Centre for Classification in Health (2002) PICQ 2002, National Centre for Classification in Health, Faculty of Health Sciences, The University of Sydney, NSW, Australia.

Use of coded data in policy development: how many ECTs are performed?

Authors Catherine Perry and Karen Walker, Health Data Standards and Systems Unit,
Department of Human Services

Many staff from different units within the department regularly use combinations of ICD-10-AM codes in analysis, upon which they base decisions for policy development. The following provides an example of how analysis of coded data has impacted on policy development. This also illustrates how analysis can be limited by questionable accuracy of coded data.

Background Information

The release of the Admission Policy has generated discussion regarding reporting of both same day and multi-day episodes for ECT to the VAED. One of the issues was whether multi-day mental health episodes (Care Type 5) should be split up so that the days when ECT occurred could be counted as an Acute Care (Care Type 4) same day episode. Some sites felt this was appropriate, because:

- ECT is always performed under anaesthetic (confirmed by the Office of the Chief Psychiatrist), which is considered by some as an 'acute' intervention.
- ECT is performed in many sites in an acute setting and/or by acute staff.
- Mental Health is block funded to provide a predetermined capacity. Some sites felt this did not adequately cover the costs of episodes that included provision of ECT, and that additional costs could be reimbursed by attracting WIES payments (by inappropriately recording Care Type 4 episodes as per the *DHS Hospital Admission Policy 2003-04*).

Reporting guidelines for 2004-05 have been clarified in the *Hospital Circular 19/2004: Subject: Electroconvulsive Therapy (ECT) Reporting* (available at: http://www.health.vic.gov.au/hospitalcirculars/). These state that

> '… where ECT occurs as part of an admitted Mental Health episode, in accordance with VAED Business Rules, the ECT must not be reported as a statistical separation. The appropriate ICD-10-AM procedure code should be assigned to the episode, with the ICD-10-AM general anaesthesia code repeated as many times as the ECT was performed (as per Australian Coding Standard 0031 *Anaesthesia*).'

Funding issues have also been flagged to be addressed for 2005-06. As published in Hospital Circular 19/2004, '…One option being considered is a co-payment for ECTs within a multi-day Care Type 5x *Approved Mental Health Service or Psychogeriatric Program* episode. …'.

Data Analysis

In order to consider the implications of various reporting and funding models for ECT, preliminary data analysis was undertaken, by searching for episodes with either 93340-00 [1907] *Electroconvulsive therapy [ECT] ≤ 8 treatments* or 93340-01 [1907] *Electroconvulsive therapy [ECT] > 8 treatments* in the code string. Analysis was also based on whether the episode was same day (admitted and separated on the same day) or multi-day (admitted and separated on different days). To project data for a full financial year the VAED data from

July-December 2003 was obtained, and then doubled. This approach was used to guard against incomplete data (included uncoded episodes) in the second half of 2003-04. The May 2004 VAED consolidated file was used for analysis. As per the data timelines in the *Victoria-public hospitals and mental health services-Policy and funding guidelines 2003-04*, all Diagnosis Records for December separations should have been transmitted to PRS/2 by the February consolidation file. Therefore the all July-December 2003 episodes (including those with ECT) should have been coded.

When considering multi-day episodes, the Funding and Financial Policy and Mental Health branches of the Metropolitan Health and Aged Care Services Division were interested in counting the number of ECTs performed in each episode. As the two ECT codes list ranges of the number of treatments, these codes did not provide exact numbers of ECT. As a surrogate, it was decided to count the number of anaesthetic codes immediately following the ECT codes. This should have been a reliable indicator of the number of ECTs performed per episode, as Australian Coding Standard (ACS) 0031 *Anaesthesia* instructs that a general anaesthesia should be coded for each 'visit to theatre' regardless of where in the hospital the procedure is performed, and that the general anaesthetic code should be sequenced 'immediately following the procedure code to which it relates'. The application of 0031 *Anaesthesia* to ECT has previously been published in *Coding Matters* (Volume 7 Number 2, September 2000), as listed below:

> 'Electroconvulsive therapy is a procedure usually performed under general anaesthesia. ECT may be performed a number of times during one episode of care. The procedure code for ECT is split on the number of times the procedure is performed:
> 93340-00 **[1907]** *Electroconvulsive therapy [ECT] ≤ 8 treatments*
> 93340-01 **[1907]** *Electroconvulsive therapy [ECT] > 8 treatments*
>
> ACS 0031 *Anaesthesia* directs coders to assign one anaesthetic code for each visit to theatre. That is, an anaesthetic code is assigned as many times as performed. ECT, on the other hand, is assigned only one code for multiple sessions.
>
> Therefore, an ECT admission where a patient undergoes 5 separate sessions of ECT, with each being performed under an intravenous general anaesthetic, will be coded as follows:
> 93340-00 **[1907]** *Electroconvulsive therapy [ECT] ≤ 8 treatments*
> 92502-00 **[1910]** *Intravenous general anaesthesia*
> 92502-00 **[1910]** *Intravenous general anaesthesia*
> 92502-00 **[1910]** *Intravenous general anaesthesia*
> 92502-00 **[1910]** *Intravenous general anaesthesia*
> 92502-00 **[1910]** *Intravenous general anaesthesia'*

Table 1 indicates that not all sites are routinely acknowledging that the ECT has been performed under anaesthetic, thus implying incomplete coding. Additionally, for patients with multi-day mental health (Care Type 5) episodes, many appear to receive ECT only once during the stay.

Table 1: Projected number of multi-day episodes (June-December 2003 data, doubled), Care Type 5, containing an ICD-10-AM ECT procedure code, and the number of anaesthetic codes immediately following the ECT code

Number of consecutive Anaesthetic Codes listed immediately after the ECT Code in the episode	Number of episodes with an ECT Code
0	430
1	2310
2	164
3	154
4	174
5	264
6	578
7	184
8	190
9	154
10	118
11	116
12	122
13	40
14	20
15	24
16	10
17	6
18	12
19	6
20	8
21	4
22	2
23	6
24	6
26	2
28	2

Analysis by site, indicates differences across sites in the application of ACS 0031 *Anaesthesia*, as can be seen in Table 2. While some sites had an average of between 3-10 ECTs per multi-day episode, nine sites had an average of one ECT per episode, indicating that they only ever coded one anaesthetic code per episode, regardless of how many ECTs were performed, or that the anaesthetic code was incorrectly sequenced before the ECT code.

Table 2: Projected number of multi-day episodes (June-December 2003 data, doubled), Care Type 5, with an ECT ICD-10-AM Procedure Code: Average number of ECTs per episode

Hospital	Number of Overnight Episodes with ECT performed	Total Number of Anaesthetic codes immediately following the ECT code for all episodes[1]	Average ECTs per episode[2]
A	***786***	***786***	***1.00***
B	222	690	3.11
C	***168***	***168***	***1.00***
D	152	774	5.09
E	146	662	4.53
F	146	422	2.89
G	140	266	1.90
H	136	736	5.41
I	122	736	6.03
J	120	744	6.20
L	112	662	5.91
M	***102***	***102***	***1.00***
N	96	614	6.40
O	86	474	5.51
P	82	562	6.85
Q	72	316	4.39
R	62	444	7.16
S	***62***	***62***	***1.00***
T	52	520	10.00
U	24	42	1.75
V	22	148	6.73
W	22	98	4.45
X	***12***	***12***	***1.00***
Y	10	52	5.20
Z	10	36	3.60
AA	***4***	***4***	***1.00***
BB	4	20	5.00
CC	4	40	10.00
DD	***4***	***4***	***1.00***
EE	***2***	***2***	***1.00***
FF	***2***	***2***	***1.00***

1: The number of anaesthetic codes sequenced immediately after an ECT procedure code, indicates the number of times ECT was performed within the episode.
2: Sites listed in bold and italics indicates that they always had only one anaesthetic code in an episode containing an ECT procedure code.

Where to from here?

The release of *Hospital Circular 19/2004: Subject: Electroconvulsive Therapy (ECT) Reporting* offers hospitals the opportunity to examine their ECT coding practices, with the knowledge that data relating to ECTs will be reviewed during in 2004-05. This will enable an accurate review of the current ECT funding mechanism, with a view to changing this for 2005-06. It has been flagged that these episodes may be targeted in the next VAED audit.

It is recommended that all sites performing ECT take advantage of this opportunity to review coding practices in relation to the application of ACS 0031 *Anaesthesia*.

Summary

This article has discussed the use of ICD-10-AM codes, in combination with other data items of the episode, to inform policy development (which may then impact on funding models) in relation to ECT. Specifically, it highlights the importance of applying ACS 0031 *Anaesthesia* in multi-day episodes that include ECT.

The more general message is that it is essential for coders to apply all ACS for all episodes. Good coding is useful for many purposes: meeting reporting requirements, funding, research, quality activities, planning, and policy development. Staff at DHS frequently access VAED data using numerous combinations of individual codes, and you will not be able to tell in advance which standards are important to follow and those that are perceived to be 'less important'. We are not able to predict which data items or codes will be used next.

In this instance the Health Data Standards and Systems Unit (HDSS) was undertaking the analysis, and could readily take coding issues into account. These coding issues are not always easily adjusted for, nor are HDSS always involved or consulted about data analysed using ICD-10-AM codes.

References

DHS Hospital Admission Policy 2003-04 (available at: http://www.health.vic.gov.au/hdss/vaed/admpol0304.pdf)

Hospital Circular 19/2004: Subject: Electroconvulsive Therapy (ECT) Reporting (available at: http://www.health.vic.gov.au/hospitalcirculars/).

Sections of quoted from NCCH ICD-10-AM, 4th Edition, July 2004 (eBook)

Victoria – public hospitals and mental health services - Policy and funding guidelines 2003-04 (available at: http://www.health.vic.gov.au/pfg2003/)

Selection ICD-10-AM coding queries

#1957 Diabetes with hypertension

75-year-old patient admitted with unsteadiness and dizziness. Query CVA, so CT head organised and patient had 8 hours of observation in ED. Also NIDDM, hypertension. CT head normal, BSLs performed x1 and normal. Patient noted to be very hypertensive over several hours, so medications altered. Sent home for review by GP next day in regard to medications. Principal diagnosis: Hypertension.
If the index entry is followed for Diabetes, with hypertension, then this episode would be coded to:
E11.9 *Type 2 diabetes mellitus without complication*
I10 *Essential (primary) hypertension*
Is this correct, it seems unusual to code this with diabetes as principal diagnosis?

The correct codes to assign in this scenario are:
E11.9 ***Type 2 diabetes mellitus without complication***
I10 ***Essential (primary) hypertension***
Hypertension is a significant co-morbidity with diabetes.

This is consistent with previous advice published by the NCCH. Conditions listed in the index under 'Diabetes, with' should be coded, regardless of other known or contributing causes.

ICD-10-AM Fourth Edition note
In ICD-10-AM Fourth Edition, diabetes with hypertension is indexed to
E1x.72 ***Diabetes mellitus with features of insulin resistance***

#1967 In-stent restenosis of coronary artery

We have a large cardiology department at our hospital and patients are often discharged with a diagnosis of in-stent restenosis of a coronary artery. Previously, when coding in-stent restenosis that occurred more than one month after the original stent insertion, we have assigned only I25.11 *Atherosclerotic heart disease of native coronary artery*, assuming it was a natural progression of the disease. This is supported by NCCH #1532 *Stenosis of a stent of the heart* which states "Where 'restenosis' is documented, with no further clarification of aetiology, the following directions apply: Where the restenosis has occurred within one month of the original procedure, assign a code relating to the complication. Where the restenosis has occurred more than one month after the original procedure, and is not related to a post procedural complication, assign a code relating to the cardiac condition requiring investigation and/or treatment".

An alternative for coding in-stent restenosis of the PDA is:

T82.8 *Other complications of cardiac and vascular prosthetic devices, implants and grafts*
Y83.1 *Surgical operation with implant of artificial internal device*
Y92.22 *Health service area*

I am now confused about which codes should be assigned.

Question 1

Can you confirm what codes we should be assigning when re-stent stenosis occurs more than one month after the original stent insertion? If it is decided that we should assign T82.8, Y83.1 and Y92.22 in addition to I25.11, please explain the reasoning behind this.

Question 2

Can you confirm whether this applies to in-stent stenosis of all arteries for example renal artery?

Question 1

If there is a cause other than progression of disease documented for an in-stent restenosis, codes should be assigned accordingly.

Otherwise, when in-stent restenosis occurs in a coronary artery more than one month after surgery, it is correct to follow ACS 0934 *Cardiac revision/re-operation procedures*, and assign a code for the cardiac condition requiring surgery.

Patients admitted within one month of the original surgery for a revision or re-operation due to a complication of the initial procedure should have a principal diagnosis relating to the complication.

Question 2

This information in ACS 0934 *Cardiac revision/re-operation procedures* is intended for use for cardiac revision procedures only and does not apply to stenosis of all other arteries (per NCCH query 783).

#1972 Percutaneous removal of inferior vena cava filter

Please advise on the correct codes to assign for percutaneous removal of an Inferior Vena Cava (IVC) filter via a digital subtraction angiography (DSA) of the abdomen.

The description of the procedure stated:
'Under ultrasound and fluoroscopic guidance, the right internal jugular vein was punctured and dilated with a 12 French dilator. The retrieval device was inserted, via which a contrast run was performed, which demonstrated no significant thrombus within the filter. The hook was snared and sheathed within the retrieval device and removed without complication.'

I have two suggestions:

90222-01 [739]	*Other procedures on vein*
60024-00 [1994]	*Digital subtraction angiography of abdomen, less than or equal to 3 data acquisition runs*
or	
92202-00 [1908]	*Removal of therapeutic device, not elsewhere classified*
60024-00 [1994]	*Digital subtraction angiography of abdomen, less than or equal to 3 data acquisition runs*

This query was referred to the NCCH for advice.

Currently there is no code in ICD-10-AM to classify removal of an IVC filter. The case cited describes a significant procedure performed on the vein in order to retrieve the IVC filter ('the right internal jugular vein was punctured and dilated').

The following combination of codes should be used to classify this procedure:

90222-01 [739]	***Other procedures on vein***
92202-00 [1908]	***Removal of therapeutic device, not elsewhere classified***
60024-00 [1994]	***Digital subtraction angiography of abdomen, <= 3 data acquisition runs***

The NCCH will consider the addition of new codes, to classify removal of an IVC filter, in a future edition of ICD-10-AM.

#1979 Removal of cardiac event monitor

We would like advice on which procedure codes to assign for removal of a 'Reveal' device (an implantable loop recorder - a patient activated cardiac event monitor placed just under the patient's skin in the chest area).
Is Z45.0 *Adjustment and management of cardiac device* the appropriate principal diagnosis code to assign? What procedure codes do you suggest?

The correct code to assign for the removal of a 'Reveal' device is:
Incision
-skin (subcutaneous tissue) 90661-00 [1608]

90661-00 [1608] ***Other incision of skin and subcutaneous tissue***

In ICD-10-AM Fourth Edition, there are four new procedure codes for management of cardiac monitoring devices (insertion, revision, removal and monitoring).

Z45.0 *Adjustment and management of cardiac device* is an appropriate principal diagnosis for this episode.

#1980 Peri-prosthetic fracture of femur

A patient presented with a peri-prosthetic fracture of the right proximal femur following an unspecified fall. A hemiarthroplasty for the initial fracture of the right femur was performed three weeks previously.
Can the Committee please advise on the correct coding of peri-prosthetic fracture of the right proximal femur occurring after the patient had an unspecified fall? I have used the following codes:

M96.6 *Fracture of bone following insertion of orthopaedic implant, joint prosthesis or bone plate*

S72.40 *Fracture of lower end femur*

W19 *Unspecified fall*

Y92.22 *Health service area*

If the code M96.6 can not be used in this scenario can the Committee please advise when the code M96.6 can be used?

As this fracture was sustained as a result of a fall, it should be assigned a code from the injury chapter. M96.6 *Fracture of bone following insertion of orthopaedic implant, joint prosthesis or bone plate* should be reserved for fractures that occur during surgery, or are due to the presence of the device. In this scenario, refer to the lead term 'Fracture':

S72.8 ***Fractures of other parts of femur***
Z96.64 ***Presence of hip implant (if meets ACS 0002 Additional diagnoses)***
W19 ***Unspecified fall'***
Y92.9 ***Unspecified place of occurrence***
U73.9 ***Unspecified activity***

NCCH query Q1527 advises that 'M96.6 *Fracture of bone following insertion of orthopaedic implant, joint prosthesis, or bone plate* should be assigned only when a fracture (and no other type of complication) is a result of the insertion or presence of these devices.'

The code M96.6 *Fracture of bone following insertion of orthopaedic implant, joint prosthesis, or bone plate* is referenced in the index under the lead term 'Complication'.

It was noted that the inquirer described the fracture as being of the proximal femur, however the suggested code was a fracture of the lower end of the femur. The inquirer should verify the site of the fracture, and code accordingly. It was also noted that Y92.22 *Health service area* would not be the correct place of occurrence, as this corresponds to the diagnosis code instead of the external cause code. Refer to Victorian Coding Newsletter, May 2003 article *'Place Of Occurrence Codes For External Causes Related To Surgical/Medical Care'*.

#1982 Radical laparoscopic prostatectomy

Could you please inform us of how to code radical laparoscopic prostatectomy? The pathology states that the seminal vesicles and iliac lymph nodes were removed. Do we code: 37209-00 [1167] *Radical prostatectomy* (classified as open) and 30390-00 [984] *Laparoscopy*? Or do we code: 37203-06 [1166] *Other closed prostatectomy* 30390-00 [984] *Laparoscopy* 90282-02 [811] *Radical excision of lymph nodes of other site* 90393-00 [1168] *Excision of seminal vesicle?*

The procedure should be coded as an open procedure, as a laparoscopy is not a closed procedure in the same way as an endoscopic procedure, where there are no incisions made.

The correct index trail to follow would be:
Prostatectomy
--perineal, retropubic or suprapubic
---radical (total) 37209-00 [1167]

It is a deficiency of the index that there is no clear choice for laparoscopic prostatectomy, and the Committee will request that the NCCH review this indexing.

As instructed in **ACS 0023 *Laparoscopic/arthroscopic/endoscopic surgery***, a code for laparoscopy should be assigned in addition to the other procedure codes.

Therefore, the Committee agrees with the first set of codes suggested:
37209-00 [1167] ***Radical prostatectomy*** (includes excision of seminal vesicles)
30390-00 [984] ***Laparoscopy***

The Committee would also assign a code for the excision of iliac lymph nodes ('code also when performed' at 37209-00 [1167]).
90282-02 [1167] ***Radical excision of lymph nodes of other site***

Documentation should be checked for mention of bladder neck reconstruction in conjunction with this procedure, as it may be appropriate to assign:
37211-00 [1167] ***Radical prostatectomy with bladder neck reconstruction and pelvic lymphadenectomy***
This code encompasses all procedures in this scenario.

#1985 Induction of labour without delivery

We have quite a few patients who are induced for social reasons. The usual procedure is to administer 1mg Prostin per vagina. If the patient does not commence labour within a given amount of time, a second dose of Prostin is given. Most patients proceed to labour and delivery, however some do not, and are discharged home.
My query concerns the patients who are discharged home undelivered. We have always used O26.88 *Other specified pregnancy-related conditions* for social induction when we have no other obstetric/medical problem. However I recently found the following pathway on the 3M Encoder:
Induction - as admitting diagnosis only
- other normal pregnancy
--with non-obstetric complaint
leads to codes Z34.8 *Supervision of other normal pregnancy* and Z34.9 *Supervision of normal pregnancy, unspecified*.

What is the correct code to use when labour is induced for social reasons, without obstetric complications, and the patient is discharged home undelivered?

This query was referred to the NCCH for advice.

A code from **Z34.-** ***Supervision of normal pregnancy*** is appropriate for documentation of social induction without indication for induction and without delivery. Ensure that there is no documentation of 'failed induction'.

However, in accordance with DHS Hospital Admission Policy, this is (generally) a situation where that patient should be placed on [normal] leave, rather than recording a separate admission and separation. The June 2004 Special Edition Coding Newsletter (page 27) states 'Specifically, where patients are admitted for induction and are subsequently sent home to wait for established labour, they should be put on leave (as you are expecting the patient to return within seven days), rather than be separated with a new admission recorded when they return'. Thus, the delivery would have occurred within the admission in question.

#1990 Rhabdomyolysis and compartment syndrome, non-traumatic

Are you able to advise if the non-traumatic codes for rhabdomyolysis and compartment syndrome are the most appropriate?

Rhabdomyolysis is the breakdown of muscle fibres, which results in myoglobin being released into the blood stream where it is a toxic compound that can lead to kidney damage, muscle necrosis, dehydration and/or shock. I would have thought that M62.5- *Muscle wasting and atrophy NEC* would be a more appropriate code than M62.8- *Other specified disorders of muscle*, as it is this, but in a very acute form. The code M62.5- does not contain the word 'chronic'. In its traumatic form, the code is T79.6 *Traumatic ischaemia of muscle*, in which case, if the word 'infarction' was not in code *M62.2- Ischaemic infarction of muscle*, this would perhaps be the more appropriate code.

Compartment Syndrome is the build up of pressure within a muscle group to the point where circulation to the area is compromised and the muscle becomes ischaemic. Once again, if the word 'infarction' was removed from M62.2- *Ischaemic infarction of muscle*, this would appear to be a more appropriate code than M62.8-. There is also an exclusion note under M62.2- for compartment syndrome (T79.6) (no specification here for traumatic).

If M62.8- is the most appropriate code for the two conditions, should there be an exclusion note on this for the traumatic form of the two conditions?

This query was referred to the NCCH for advice.

Amendments to the classification and indexing of 'non-traumatic compartment syndrome' in ICD-10 have been ratified by the Update Reference Committee of the WHO. The NCCH will make appropriate amendments to the classification and indexing of this condition for ICD-10-AM Fifth Edition.

In the meantime, continue to follow the index entries for compartment syndrome.

#1991 Drainage of chest / pleura

When coding a record for a patient who underwent insertion of pleural catheter for drainage of pleural effusion, I have noticed that there appears to be an inconsistency in the index regarding drainage of chest and drainage of pleura.
Drainage of chest has index entries for 'open': 38415-00 [549] *Incision of pleura*, and 'closed': 38409-00 [560] *Insertion of intercostal catheter for drainage*. Drainage of pleura is only indexed to 'open' (38415-00 [549] Incision of pleura).
The dictionary definition of thoracocentesis is drainage of the thoracic cavity including the pleura.

Should there be an index entry for 'closed' drainage of pleura—38409-00 [560] *Insertion of intercostal catheter for drainage*.

This query was referred to the NCCH for advice.

Closed (endoscopic) drainage of the pleura should be classified as
38409-00 [560] ***Insertion of intercostal catheter for drainage*.**

The NCCH will consider the addition of appropriate entries for this code to the Alphabetic Index of Procedures for a future edition of ICD-10-AM.

#1993 Placement of angioseal after angiogram / angioplasty

Our coronary care unit has started using angioseals after performing angiograms and angioplasties. It is a collagen sponge with an absorbable polymer anchor that is connected by an absorbable positioning suture. It is placed into the artery to prevent haematoma or haemorrhage, particularly in patients whose artery has been punctured before.

Information from our cardiologist indicates that this is a separate procedure performed after the main procedure, and requires the clinician to re-gown and glove. The device itself costs approximately $300. Due to the extra use of resources, it seems appropriate to assign a code.

Embolisation
-arteriovenous fistula or malformation
--via surgical peripheral catheterisation 35321-00 [767]

35321-00 [767] *Transcatheter embolisation of blood vessel*
Includes: Administration of an agent or device such as glue, ethanol, plastic or gelatin sponge, balloon or wire coil to occlude artery, vein, arteriovenous fistula or malformation or to arrest haemorrhage'
This is a perfect description of the procedure.

Assigning this code can have a dramatic effect on the version 4.2 grouping. Hence, we decided to send a query so that this anomaly can be notified to the appropriate body.

Example 1 AMI, angiogram performed and angioseal placed.
I21.4 *Acute subendocardial myocardial infarction*
38218-00 [668] *Coronary angiography with left heart catheterisation*
59900-00 [607] *Left ventriculography*
groups to DRG F41B Circ Dis w AMI W Inv Car Pr No C/S CC (weight 1.6162)

I21.4 *Acute subendocardial myocardial infarction*
38218-00 [668] *Coronary angiography with left heart catheterisation*
59900-00 [607] *Left ventriculography*
35321-00 [767] *Transcatheter embolisation of blood vessel*
groups to DRG F14C Vasc Prs Exc Maj Rec w/o Pump w/o C/S CC (weight 0.9795)

Example 2 Carotid occlusion, angioplasty performed and angioseal placed.
I65.2 *Occlusion and stenosis of carotid artery*
35303-06 [754] *Percutaneous transluminal balloon angioplasty*
groups to DRG 901Z Extensive OR procedure Unrelated to Principal Diagnosis (weight 3.2220)

I65.2 *Occlusion and stenosis of carotid artery*
35303-06 [754] *Percutaneous transluminal balloon angioplasty*
35321-00 [767] *Transcatheter embolisation of blood vessel*
groups to DRG B02C Craniotomy w/o CC (weight 3.0514)

By assigning the angioseal code in this instance, it groups to a craniotomy DRG which is definitely incorrect, and not an accurate description of what occurred during the admission.

Please advise:
1. Should we be coding this procedure?
2. Is 35321-00 [767] the correct code to use?
3. If the answer to these questions is yes, our hospital will be financially disadvantaged by the DRG assignment, until such time that the grouping can be fixed. Will this be addressed?

A code for the placement of an angioseal should not be assigned. This device is used as a mechanical system for sealing the entry wound caused by angioplasty. At the end of the procedure, the device is positioned under the skin at the site of the puncture, so as to achieve effective haemostasis. (http://www.chfpatients.com/surgery_old.htm#cathseal)

This is not embolisation of a vessel. Placement of an angioseal is a component of an angioplasty procedure, as the vessel would always be sealed, and, therefore, according to ACS 0016 *General procedure guidelines* should not be coded.

#1956 Basic concepts of diabetes coding

Question 1

Can diabetes be coded as an associated condition based on one BSL alone? We had discussed and agreed that using monitoring as a basis for meeting additional diagnosis, more than one BSL would be required according to definition and one level is just a baseline observation always done on admission as part of the nursing admission process (along with urinalysis, resps, pulse, BP, filling out paperwork, medications etc). If it can be coded based on one BSL alone how does this meet additional diagnosis?

Question 2

How do you code diabetes with ESRF?

E1x.23 *Diabetes Mellitus with end-stage renal disease*
(as the clinical diagnosis is fully described by the code description)
or
E1x.23 *Diabetes Mellitus with end-stage renal disease*
N18.0 *End-stage renal disease*

Question 3

How do you code diabetes with PVD (without claudication, rest pain, ulcer or gangrene)?

E1x.51 *Diabetes Mellitus with peripheral angiopathy, without gangrene*
or
E1x.51 *Diabetes Mellitus with peripheral angiopathy, without gangrene*
I70.20 *Atherosclerosis of arteries of extremities, unspecified*

Question 4

How do you code diabetes with PVD with (non-foot) lower limb ulcer?

E1x.51 *Diabetes Mellitus with peripheral angiopathy, without gangrene*
I70.23 *Atherosclerosis of arteries of extremities with ulceration*
or
E1x.69 *Diabetes Mellitus with other specified complication*
L97 *Ulcer of lower limb, not elsewhere classified*
E1x.51 *Diabetes Mellitus with peripheral angiopathy, without gangrene*
or
E1x.69 *Diabetes Mellitus with other specified complication*
L97 *Ulcer of lower limb, not elsewhere classified*
E1x.51 *Diabetes Mellitus with peripheral angiopathy, without gangrene*
I70.20 *Atherosclerosis of arteries of extremities, unspecified*

Question 1
BSLs are not done routinely for every patient admitted to hospital, and are not always done for a patient with diabetes. If a single BSL reading were taken for a diabetic patient, this would satisfy the requirement for coding diabetes, as specified in ACS 0002 *Additional Diagnoses*, specifically by requiring 'increased nursing care and/or monitoring'.

This question is answered in the NCCH 3rd Edition Education Program - FAQs - Part 2, in a question related to diabetes. The NCCH's answer is to code diabetes when it meets the criteria in ACS 0002 *Additional Diagnoses*. The taking of BSLs is one indication that diabetes mellitus meets criteria of ACS 0002.

Question 2
The correct code to assign for diabetes with ESRF is
E1-.23 *Diabetes Mellitus with end-stage renal disease*.

Although this advice is not consistent with that provided in NCCH database Q1349, the NCCH have verified that, for ICD-10-AM 3rd edition, this answer is correct.

Note that in ICD-10-AM Fourth Edition the code title has changed and an additional code to identify end stage renal failure is required.

Question 3
NCCH 3rd Edition Education Program - FAQs - Part 1, in an example related to diabetes, it was stated that an additional code for peripheral angiopathy NOS 'is not required ….as the concept is covered in the code title of E10.51 Type 1 diabetes mellitus with peripheral angiopathy, without gangrene.'

The correct code for diabetes with PVD (without claudication, rest pain, ulcer or gangrene) is
E1-.51 *Diabetes Mellitus with peripheral angiopathy, without gangrene*.
The addition of I70.20 *Atherosclerosis of arteries of extremities, unspecified* does not add any information.

Question 4
The correct codes to assign in this scenario depend on the documentation, and the relationship between the conditions.
If the ulcer is related to the PVD, then the correct codes would be:
E1-.51 *Diabetes mellitus with peripheral angiopathy, without gangrene*
I70.23 *Atherosclerosis of arteries of extremities with ulceration*

If there is no documented relationship between the ulcer and the PVD, the correct codes would be:
E1-.69 *Diabetes mellitus with other specified complication*
L97 *Ulcer of lower limb, not elsewhere classified*
E1-.51 *Diabetes mellitus with peripheral angiopathy, without gangrene*.

#1995 Diagnosis code for failed vacuum extraction

Please confirm whether we are to follow 'and' (in code title), or 'or' (in the inclusion term), in the following code:

O66.5 *Failed application of vacuum extractor and forceps, unspecified*
Failed application of ventouse or forceps, with subsequent delivery by forceps or caesarean section respectively.

As there are the following procedure codes:

90468-05 [1337] *Failed forceps*

90469-01 [1338] *Failed vacuum extraction*

Discussion amongst our coders has revealed that not many use **O66.5**, as they feel that they have covered the scenario with these procedure codes.

Is it essential that O66.5 be coded in addition to the procedure codes? If so, do we follow the 'and' or the 'or' direction?

ACS 0033 ***Conventions Used in the Tabular List of Diseases*** provides instruction on how to interpret 'and' in code titles:
In disease codes 'And' stands for 'and/or'. For example, in the rubric A18.0† Tuberculosis of bones and joints, are to be classified cases of 'tuberculosis of bones', 'tuberculosis of joints' and 'tuberculosis of bones and joints.

This convention does not apply to inclusion terms.

A disease code should be assigned for a failed vacuum extraction. This will be a code to indicate the reason why the procedure failed, or, in the case where the reason is not documented, assign a code for the failed vacuum extraction, by following the index pathway:
Failure
-ventouse (with subsequent caesarean section) NEC O66.5

O66.5 ***Failed application of vacuum extractor and forceps, unspecified***

The fact that there are procedure codes to demonstrate the events of the admission is not reason to omit disease codes. It is common for disease codes to be assigned when there are also procedure codes to describe the scenario.

#1996 Reopening and rewiring of sternotomy

When a patient has reopening of sternotomy for control of post-operative haemorrhage, the sternum is not always rewired at the same time but can be done some time later. When the sternum is rewired during the same operative episode, should it be coded in addition to reopening?
That is:
38656-01 [562] *Reopening of thoracotomy or sternotomy site*

and

90596-00 [1378] *Rewiring of sternum*
Or is the rewiring inherent in the reopening code? This is not clear in the Procedure Tabular, as there are no notes under these codes to direct us either way. I can find no reference in the Australian Coding Standards or on the NCCH database of queries.

In this scenario, the patient's original sternotomy was re-opened, the post-operative haemorrhage controlled, then the sternotomy rewired in the same operative episode, which would be considered closure of the operative incision.

Reference was made to ACS 0016 General procedure guidelines, specifically:

> **'Procedure components**
> Do not code procedures which are individual components of another procedure.
>
> **EXAMPLE 2:**
> •laparotomy as an operative approach
> •bone graft during craniofacial reconstruction
> •suture of abdominal incision after surgery'

Therefore, a code for the rewiring component of this procedure should not be assigned in this scenario.

#1998 Neoplasm causing obstruction of biliary stent

Is it acceptable to code the cancer as principal diagnosis in the case of patient who came in with blocked biliary stent documented as due to advancement of liver cancer? The stent was removed and, after a range of investigations, care became palliative only.
If coding:
T85.88 *Other complications of internal prosthetic, device, implant and graft, NEC*
as principal, the **DRG X63 *Sequelae of Treatment*** did not seem to reflect the picture well. If coding the cancer as principal, the **DRG H41 *ERCP Complex Therapeutic Procedure*** seemed to fit much better.

As it was the advancement of the tumour, which caused the stent to be blocked, assign as the principal diagnosis a code for the liver cancer.

DRG outcome should not determine principal diagnosis assignment; it should be used as a quality check only.

#2002 Documentation of American Society of Anesthesiologists (ASA) score

Can you please advise whether it is appropriate to use the American Society of Anesthesiologists (ASA) score documented on the operation nursing form when the ASA score is not documented on the anaesthetic record? This information is obtained from the anaesthetist by the perioperative nursing staff.

ACS 0031 states 'this information must be documented on the anaesthetic form before assigning these codes'.

The inquirer is correct in referring to **ACS 0031 *Anaesthesia*** where it is stated that this information must be documented on the anaesthetic form before assigning these codes.

An ASA score documented on the operation nursing form should not be used for code assignment.

#2006 Diabetes with septic arthritis

90-year-old female admitted for amputation of toe because of septic arthritis. Patient also has Type II Diabetes, toe ulcer and peripheral vascular disease (PVD). Had toe amputated, and then developed a haematoma and a post-operative wound infection (Staph. Aureus). The following codes were assigned:

M00.97	*Pyogenic arthritis, unspecified, ankle and foot*
E11.73	*Type 2 diabetes mellitus with foot ulcer due to multiple causes*
I70.23	*Atherosclerosis of arteries of extremities with ulceration*
T81.0	*Haemorrhage and haematoma complicating a procedure, not elsewhere classified*
T81.41	*Wound infection following a procedure*
B95.6	*Staphylococcus aureus as the cause of diseases classified to other chapters*
Y83.5	*Amputation of limb(s)*
Y92.22	*Health service area*
44358-00 [1533]	*Amputation of toe including metatarsal bone*
92508-49 [1909]	*Neuraxial block, ASA 49*
30223-00 [1606]	*Incision and drainage of haematoma of skin and subcutaneous tissue*
95550-03 [1916]	*Allied health intervention, physiotherapy*

Are these codes correct? Arthritis is not indexed under 'Diabetes', however, arthropathy is, but according to NCCH database query 1677, I cannot make a connection.

The inquirer is correct in stating that no connection can be made between septic arthritis and diabetes. There is no index entry for 'Diabetes with arthritis', and the term 'arthropathy' cannot be referenced as an alternative for 'arthritis'. This advice is confirmed in Coding Matters (Vol.8, No.2, p10), and in NCCH query database Q1677.

Peripheral Vascular Disease and toe ulcer are conditions that meet the criteria for assigning a code for diabetic foot (**ACS 0401 *Diabetes***).

Therefore, the Committee agrees with the inquirer's suggested disease codes.

Without further information, the procedure codes cannot be confirmed.

#2007 DRG 902Z with dilatation and curettage

A relatively rare procedure was performed - excision of urethral diverticulum, but as it was performed with a dilatation and curettage (D & C) for menorrhagia, it groups to DRG *902Z Non-Extensive OR Proc Unrelated to Pdiag*.

In theory, we could reverse the order and have menorrhagia and D & C first, which groups to DRG N10Z *Diagnostic Curettage or Hysteroscopy*, but documentation by the clinician indicates that the diverticulum would be the principal diagnosis.
As it is a rare diagnosis and procedure, and as 'excision' is overriding a D & C, thought you may like to have a look.

Codes assigned:

N36.1	*Urethral diverticulum*
N92.0	*Excessive and frequent menstruation with regular cycle*
Z30.1	*Insertion of (intrauterine) contraceptive device*
Z72.0	*Tobacco use, current*
37372-00 [1118]	*Excision of urethral diverticulum*
35640-00 [1265]	*Dilation and curettage of uterus [D&C]*
35630-00 [1259]	*Diagnostic hysteroscopy*
14203-00 [1906]	*Direct subdermal hormone implantation*
92514-29 [1910]	*General anaesthesia, ASA 29*

Based on the codes provided, the DRG assignment is correct. Current grouper logic assigns this episode to DRG 902Z *Non-Extensive OR Proc Unrelated to Principal Diagnosis* as N36.1 *Urethral diverticulum* as principal diagnosis is in MDC 11 *Disease and disorders of the kidney and urinary tract* and 35640-00 [1265] *Dilation and curettage of uterus* is in MDC 13 *Disease and disorders of the female reproductive system* and 14 *Pregnancy, childbirth and the puerperium*.

37372-00 [1118] *Excision of urethral diverticulum* is not recognised as an operating room procedure by the grouper.

#2009 Applying ACS 0002 Additional diagnoses

We are having trouble applying ACS 0002 *Additional diagnoses* in the following two scenarios.

Scenario 1
A 70-year-old patient comes in with 'Exacerbation of COPD'. A geriatrician sees the patient stating that they have 'osteoporosis' and makes a comment recommending 'Osteolin, Caltrate, Vit D' (which was not commenced during this admission). Does this warrant coding osteoporosis based on the geriatrician's recommendation?

Scenario 2
An 84-year-old patient is treated for 'R knee pain secondary to osteoarthritis'. In the doctor's initial assessment, she comments that the patient had '[decreased] memory, STM 0/3 (amnesic type)'. The dementia did not affect the nursing care given during the episode of care, but the treating doctor documented 'dementia' on the discharge summary and 'Refer to memory clinic'.
Can dementia be coded?

Please clarify whether these conditions meet ACS 0002 and can be coded.

Scenario 1
The Victorian ICD Coding Committee supports the coding of osteoporosis in this scenario as the patient has had active evaluation and active decisions have been made. Please refer to *Additional diagnoses queries and responses query 14 Pneumonia and dehydration* on the HDSS website for further guidance.

Scenario 2
The dementia has been actively evaluated and an active decision has been made. Dementia can be coded in this instance.

#2010 Angina with history of ischaemic heart disease (IHD)

Patient admitted with and treated for angina. Ischaemic heart disease (IHD) noted on the history sheet. Is the angina the result/ outcome of the IHD, and therefore, IHD need not be coded, or should the IHD be coded as an additional diagnosis?

The inquirer should refer to **ACS 0940 *Ischaemic heart disease*** for definitions of both angina and ischaemic heart disease. The standard states:

> 'Patients documented as having the current conditions of both ischaemic heart disease and angina can have both **I25.9 *Chronic ischaemic heart disease***, unspecified and **I20.9 *Angina pectoris***, unspecified assigned.'

In this scenario, a code for angina should be assigned as the principal diagnosis, and, if the ischaemic heart disease meets the criteria in **ACS 0002 *Additional diagnoses*** (for example, investigation and diagnosis of coronary artery disease), a code should also be assigned for this condition.

#2011 Neonate with melaena due to ingestion of maternal blood

We had an episode group to DRG 963Z *Neonatal Diagnosis inconsistent w weight*. Although the description of the DRG indicates discrepancies with diagnosis and weight, is this DRG also assigned on the basis of diagnosis and baby's age?

In this case the patient was 28 days old on admission, with a diagnosis of 'Melaena secondary to ingestion of maternal blood (from breast feeding)' and an admission weight of 3572g. A code from 'P' chapter was assigned. As the baby was beyond the age for a neonate, yet a neonatal code was assigned, would this be why this episode grouped to 963Z?

Would it be appropriate to assign two codes for this episode?
K92.1 *Melaena*

P78.2 *Neonatal haematemesis and melaena due to swallowed maternal blood*

This ensures a funded DRG plus gives a clear indication of the cause of the melaena.

This episode groups to DRG 963Z *Neonatal Diagnosis inconsistent with weight* because you have used a principal diagnosis from the 'Conditions arising in the perinatal period' chapter, and the admission weight is greater than 2500 grams.

For some episodes, this DRG can be valid. This problem is acknowledged by the Victorian ICD Coding Committee and is under consideration by VACCDI.

In this instance, it is correct to assign only
K92.1 *Malaena*.

The logic behind this advice is based on that provided in Coding Matters (Vol 5, No 1, p 16), in which there is a direction to refer to the main index term 'Jaundice' if the infant is greater than 28 days old.

#2013 Displaced fractures

Patient admitted with a displaced fracture of distal fibula and fracture of distal tibia.
Volume 1 of ICD-10-AM 3rd edition page 375 lists definitions of types of fractures; this list includes the term 'displaced'. There is also an index entry for Displacement, acquired traumatic of bone, cartilage, joint, tendon (without fracture) NEC - see Dislocation.
My query is whether the term in brackets as a non-essential modifier should in fact be an essential modifier?
Some of our coders have been following this index entry for displaced fractures and coding a fracture and a dislocation, which I do not believe to be correct, but the index is misleading.
Thank you for considering this matter.

The correct index entry to follow is Fracture, by site.
The Victorian ICD Coding Committee will request that NCCH remove the index entry for 'see Dislocation'.

#2014 Continuous ventilatory support hours following tracheostomy

We often have difficulty calculating the period of mechanical ventilation (CVS) for people with a tracheostomy. The issue surrounds the definition of 'weaning'. ACS 1006 *Respiratory support* states 'cessation of CVS for patients with a tracheostomy (after any period of weaning)'. The August 2002 ICD Coding Newsletter has a coding feature about CVS which states 'when a patient has a tracheostomy it is harder to determine when ventilation/weaning ceases as the tracheostomy tube is often left in-situ in case the patient needs further ventilatory support. Therefore to determine when CVS has ceased in a tracheostomy patient, stop the count at the time of the last recording of pressure support'. How do we determine the last recording of pressure support?

Often patients with a tracheostomy alternate between being on pressure support and being off pressure support (for example using a face mask). Our ICU has advised us that in this situation, the period of time spent on the face mask (between periods of pressure support) is considered weaning. For example the patient may alternate between CPAP/BiPAP for a few hours and then a few hours using a face mask and then back onto CPAP/BiPAP. When this occurs we continue to count the time spent on the face mask as hours of mechanical ventilation, considering the time on the face mask to be 'weaning'.

The difficulty comes when the patient spends long periods of time off pressure support and then returns to pressure support. A recent example we came across was:
Patient had tracheostomy inserted on 11 February. Returned to ICU. Alternated between periods on pressure support and short periods off pressure support until 6.00am on 3 March. At this time, the patient went off pressure support and remained off pressure support until 21.00 on 5 March, at which time pressure support was re-commenced (no reason for re-commencement documented). In total, this patient spent approx 63 hours off pressure support, and then re-commenced pressure support for 10 hours. At the end of the 10 hours, the patient went off pressure support for the last time. Our question is, when calculating the total hours of MV in ICU do we include or exclude the 63 hours the patient spent off pressure support?

If we follow the guidelines above, we would include the 63 hours when calculating the total hours of MV. Is this correct? Is there a time limit to how long a patient with a tracheostomy can spend off pressure support (in between periods of pressure support) before it is considered not to be weaning?

If at the time the patient was taken off MV, there was an intention to recommence, the 63 hours should be included in the count of MV. There is no time limit for the weaning period. Coders should refer to ICU staff for clarification of documentation issues and determine if there was an intention to wean. If however the weaning period was over, then the hours are not counted. The inquirer is advised to look for documentation to determine whether the patient had ceased CVS or was in the process of weaning.

#2017 Autologous chondrocyte grafting

33-year-old male had autologous chondrocyte grafting in a hemiarthroplasty of knee for Osteochrondritis Dissecans. The most suitable code we could find was 49503-02 [1520] Chondroplasty of knee. In Block 1520 there is chondral graft with arthroscopy of knee, but in this instance, there is no arthroscopy.

In this scenario, the correct codes for autologous chondrocyte grafting are:
49503-02 [1520] ***Chondroplasty of knee***
14203-01 [1906] ***Direct living tissue implantation***

A similar query #1654 was published in the June 2001 ICD Coding Newsletter.

#2019 Diabetic foot with decubitus ulcer

For patients admitted with diabetic foot, where one of the conditions is decubitus ulcer, can you please tell me if it is warranted to assign L89 *Decubitus Ulcer* as an additional diagnosis code after E1-.73 *Diabetes with foot ulcer due to multiple causes*? Decubitus Ulcer is a clinical indicator and therefore collection of this data is often generated through diagnosis reports, however if we are not to assign L89 after E1-.73 as it is included in the code title, we are unable to capture the fact that these are decubitus ulcers. This is not an issue when the patient simply has diabetes and a decubitus ulcer as it is necessary to assign the ulcer code as an additional diagnosis code when using E1-.69

According to ACS 0033 *Conventions used in the tabular list of disease*, the main aim in coding is *'To translate medical statements into code'*. Therefore, decubitus ulcer can be assigned as an additional diagnosis code as this adds further specificity about the type of ulcer.

Fourth edition note
The codes for decubitus ulcer have changed in fourth edition (see below).

L89 Decubitus [pressure] ulcer

L89.0 Stage I
Decubitus [pressure] ulcer limited to erythema only

Note: The ulcer appears as a defined area of persistent redness (erythema) in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue or purple hues, without skin loss.

L89.1 Stage II
Decubitus [pressure] ulcer with:
- abrasion
- blister
- partial thickness skin loss involving epidermis and/or dermis
- skin loss NOS

L89.2 Stage III
Decubitus [pressure] ulcer with full thickness skin loss involving damage or necrosis of subcutaneous tissue extending to underlying fascia

L89.3 Stage IV
Decubitus [pressure] ulcer with necrosis of muscle, bone or supporting structures (ie tendon or joint capsule)

L89.9 Decubitus [pressure] ulcer, unspecified
Decubitus [pressure] ulcer without mention of stage[1]

[1] Extracted from NCCH ICD-10-AM, July 2004, Skin and Subcutaneous Tissue.

#2023 Musculoskeletal injury to thoracic spine

I am trying to code a musculoskeletal injury to the thoracic spine, there were no fracture or lacerations, therefore I am looking for an 'other specified injury of thoracic back'. The only code I have come up with is T09.8 *Other specified injuries of trunk, level unspecified*. This code is really not suitable as the level of the injury is specified. Do you have any other suggestions? Should other specified/unspecified injuries to trunk codes be reviewed to include more specificity?

Musculoskeletal injury to the thoracic spine should be coded to
S29.8 *Other specified injuries of thorax*.

The correct index look up is
Injury
-Thorax, thoracic
--Specified type NEC S29.8

#2026 Excision of gouty tophi

Excision of gouty tophi - numerous sites over two separate episodes of care (February and May 2004). Joint sites such as elbow, PIP toe, MIP toe etc. Surgeon gave Medicare Benefits Schedule (MBS) number 30068 'Removal of foreign body in muscle tendon or deep tissue'. This leads to DRG I27Z Soft tissue procedure. We feel this is not an appropriate code and checking the index, suggested 90574-00 [1561] *Excision of lesion of joint, not elsewhere classified*. Being a new code, the surgeon can't access on MBS. We feel this is a far more clinically suitable code, however the DRG attained is I23Z Local excision and removal of internal fixation device, excluding hip and femur, which may or may not be appropriate.

Can the committee suggest anything more appropriate?

The Victorian ICD Coding Committee agreed that code
90574-00 [1561] *Excision of lesion of joint, not elsewhere classified*
is the most appropriate for this procedure.

This is not a new code, rather it is a code created by the NCCH for ICD-10-AM. The NCCH created codes (beginning with 9) to represent concepts that are not found in the MBS.

#2035 Carotid sinus hypersensitivity with permanent pacemaker insertion

A patient admitted with recurrent syncope due to carotid sinus hypersensitivity undergoes insertion of permanent pacemaker. I have coded G90.0 *Idiopathic peripheral autonomic neuropathy* with codes for the pacemaker insertion but this groups to DRG 901Z *Extensive OR Procedure Unrelated to Principal Diagnosis*. Should it be more appropriately grouped to a pacemaker DRG?

This is a grouper anomaly. Patients with this condition are often treated with a permanent pacemaker insertion. You have coded this correctly.

The Victorian ICD Coding Committee has referred this issue to the Commonwealth for investigation.

Coding Standards Advisory Committee papers

The Health Data Standards and Systems Unit represents Victoria on the National Centre for Classification in Health's (NCCH) Coding Standards Advisory Committee (CSAC).

Due to the important nature of the work of the CSAC, we are seeking expressions of interest from suitably experienced coders to provide input into the work of CSAC.

CSAC terms of reference

1. Advise the NCCH on the implementation and publication of new and amended ICD-10-AM codes and Australian Coding Standards.
2. Advise the NCCH on activities and products relating to coding and coding quality measures.
3. Report to and from organisations/jurisdictions represented on this committee.
4. Ensure that standards of definition and convention are maintained when ratifying changes to ICD-10-AM and the Australian Coding Standards.
5. Review public submissions for changes to ICD-10-AM.
6. Receive feedback from users of coded data on the impact of standards and codes on current data collections.
7. Ratify coding advice from the NCCH prior to publication in Coding Matters.
8. Recommend to the Australian Department of Health and ageing, future changes to the Australian Refined – Diagnosis Related Groups classification system as they relate to coding.
9. Recommend to National Health Information Management Group the national adoption of ICD-10-AM modifications on a biennial basis.
10. Provide input to relevant authorities on morbidity and mortality coding related issues such as data edits, coding quality measurement, design of data collection systems.
11. Provide coding advice to the National Health Data Committee on definitions relating to relevant classification items in the National Health Data Dictionary.
12. Provide advice to NCCH and the Australian Bureau of Statistics on the relationship between Australian Coding Standards for morbidity coding and rules for cause of death coding.
13. Provide advice on other relevant health classification systems.

Currently HDSS circulates CSAC papers to members of the Victorian ICD Coding Committee (VICC) who are given the option to provide comments. However this work needs to be balanced against the already significant workload that VICC members already undertake, and their responsibilities in their workplace.

Participation in this group will give coders the chance to have input into future editions of ICD-10-AM. Coder input would be in the form of reviewing CSAC discussion papers, primarily draft changes to the next edition of ICD-10-AM and Coding Matters articles, and then providing comments to Victoria's CSAC representative Sara Harrison. This feedback will be summarised and then submitted to the NCCH. Volunteers should be aware that this can sometimes be time consuming and requires attention to detail. All contact will be via email, that is, there will be no need to the group to meet.

All queries and expressions of interest should be addressed to Sara Harrison (sara.harrison@dhs.vic.gov.au). Expressions of interest should include details of current employment and past coding experience. Applicants should be currently employed in a position where coding comprises a significant past of the work, have completed the most recent ICD-10-AM upgrade education package and have graduated at least three years ago from an undergraduate course in Health Information Management or Medical Record Administration or a course in Clinical Coding.

Victorian ICD Coding Committee activities

This will become a regular feature of future newsletter and will include a brief overview of the current activities undertaken by the Victorian ICD Coding Committee (VICC). Victorian coders are welcome to provide any relevant information regarding any of these issues. Please contact Sara Harrison, Secretary Victorian ICD Coding Committee (Sara.Harrison@dhs.vic.gov.au) if you would like to discuss any of these issues.

Coding queries

Following the 1 July 2004 implementation of ICD-10-AM Fourth Edition, the VICC is now addressing the large numbers of coding queries that follow the implementation of a new edition. Since 1 July we have received 57 new queries. This is keeping us very busy and we have little time for other work at this stage. (Answering queries is the main function of the VICC). For the 2003-04 year we received 105 new queries.

Public submissions

In the past few months the VICC has prepared public submissions to NCCH for:

- Coding of scans. This public submission suggested that the coding of scans (CT, nuclear, MRI etc) be reviewed. The VICC suggested that these be coded only when they are a component of another procedure (for example CT guided drainage). Suggestions to amend ACS 0042 *Procedures not normally coded* to reflect this were included in the submission.
- Cardiac catheterisation. This submission suggested amendment to ACS 0933 *Cardiac catheterisation* that make the standard clearer and more clinically correct.

We are currently working on a public submission for amendment to ACS 0002 *Additional Diagnoses* to include 'active clinical evaluation' in the criteria for coding a condition.

Notifications to Commonwealth

We have prepared and submitted notifications for several grouper anomalies to the Department of Health and Ageing for amendment in a future version of AR-DRGs.

- Permanent pacemaker insertion for carotid sinus hypersensitivity – suggestion that G90.0 *Idiopathic peripheral autonomic neuropathy* be considered an acceptable principal diagnosis for cardiac pacemaker DRG allocation
- Z71.3 *Dietary counselling and surveillance* as a CC. See comment on page 5 of this newsletter

Query database

A longer-term project being overseen by the VICC is the development of a query database for management of VICC coding queries and eventual publication of coding queries on the HDSS webpage. This database is in its early stages, and the Secretary has commenced using the database for query maintenance, however it is envisaged that it may be some time before it is available for public access on our webpage.

Victorian ICD Coding Committee members as at 1 September 2004

Jennie Shepheard	Human Services (Chair, Acting La Trobe University representative)
Carla Read	Human Services (Convener)
Sara Harrison	Human Services (Secretary, Victorian CSAC representative)
Melinda Avram	Epworth Hospital
Rhonda Carroll	The Alfred Hospital (VACCDI representative)
Annette Gilchrist	Royal Melbourne Hospital
Andrea Groom	Southern Health
Sonia Grundy	St Vincent's Hospital
Lauren Morrison	The Royal Women's Hospital
Megan Morrison	St John of God Health Care Geelong
Jade Oliver	Austin Health
Susan Peel	Healesville and District Hospital
Leanne Stokes	Beachplace Pty Ltd
Maree Thorp	Peninsula Health
Kathy Wilton	3M

Victorian ICD Coding Committee meeting dates

Tuesday 19 October	DHS, 10:00am, 16th floor 555 Collins Street, Melbourne
Tuesday 16 November	DHS, 10:00am, 16th floor 555 Collins Street, Melbourne
Tuesday 14 December	DHS, 10:00am, 16th floor 555 Collins Street, Melbourne

Abbreviations

ACBA	Australian Coding Benchmark Audit
ACS	Australian Coding Standard
ADx	Additional Diagnosis
AIHW	Australian Institute of Health and Welfare
AN-DRG	Australian National Diagnosis Related Groups
AR-DRG	Australian Refined Diagnosis Related Groups
CC	Complication or Comorbidity
CCCG	Clinical Classification and Coding Groups
CCL	Complication or Comorbidity Level
CSAC	Coding Standards Advisory Committee
DHS	Department of Human Services
DRG	Diagnosis Related Group
ESIS	Elective Surgery Information System
HDSS	Health Data Standards and Systems
HIMAA	Health Information Management Association of Australia
ICD-10-AM	Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
LOS	Length Of Stay
MDC	Major Diagnostic Category
NCCH	National Centre for Classification in Health
PDx	Principal Diagnosis
PICQ	Performance Indicators for Coding Quality
PCCL	Patient Clinical Complexity Level
VACCDI	Victorian Advisory Committee on Casemix Data Integrity
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VICC	Victorian ICD Coding Committee
WHO	World Health Organisation